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### Integrated HRA Enrollment Form – City of Cincinnati Employees

**EMPLOYER INFORMATION**

Employer Name: **City of Cincinnati**

*Please send completed enrollment forms and information to:*

City of Cincinnati Risk Management - 805 Central Avenue, Suite 100 - Cincinnati, OH 45202

Fax: 513.352.3761 / Email: [Phyliss.Ward@Cincinnati-oh.gov](mailto:Phyliss.Ward@Cincinnati-oh.gov)

For Questions Call: 877-872-4232 or email [CinciHRA@JandKcons.com](mailto:CinciHRA@JandKcons.com)

**I am enrolling in the Integrated HRA for: \_\_\_\_\_ Single \_\_\_\_\_ Family**

**PARTICIPANT INFORMATION**

|                      |                  |   |                        |
|----------------------|------------------|---|------------------------|
| Employee Name:       |                  | Birthdate:  | Hire Date:             |
| Social Security No:  | Employee ID No.: | Gender: <input type="checkbox"/> M <input type="checkbox"/> F | Date Eligible for HRA: |
| Home Street Address: |                  |   |                        |
| City:                |                  | State:  | Zip Code:              |
| Home Phone:          |                  | Work Phone:   | Cell Phone:            |
| Email Address:       |                  | Fire, Police or Union Affiliation:                            |                        |

**SPOUSE INFORMATION**

|  |                    |   |
|--|--------------------|---|
| Spouse Name:   | Birthdate:         | Gender: <input type="checkbox"/> M <input type="checkbox"/> F |
| Social Security No:  | Spouse's Employer: |   |
| Spouse's Pay Period for Health Premium Contribution: <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Weekly |                    |   |
| Spouse's Health Premium Contribution Pay Period: _____ <b>** INCLUDE DOCUMENTATION, I.E. PAYSTUB OR BENEFIT STATEMENT</b>  |                    |   |
| Are Spouse's Health Premium Contribution / Deductions: <input type="checkbox"/> Before Taxes <b>(OR)</b> <input type="checkbox"/> After Taxes  |                    |   |

\* Contribution per pay period should include the cost for Medical only; Dental & Vision are not covered under this plan. If submitting a spousal paystub, please circle the contribution/deduction amount on the submitted paystub. DO NOT BLACKOUT THE PAY PERIOD.  
 \*\* Send a copy of your spouse's paystub that shows the NEW contribution/deduction amount for the effective date listed above. This amount should reflect the cost of adding you and/or any dependents to the spouse's plan. *Please indicate if the medical deduction DOES NOT come out of every paycheck. Some may be only once a month or the first two pays of each month.*  
 \* If your spouse's plan has a High Deductible with an HSA, Health Savings Account, you are not eligible to participate in the Integrated HRA, unless the spouse's employer allows your spouse to drop the HSA portion of the plan. **If your primary health insurance coverage is through Medicare, Tricare, or any City of Cincinnati sponsored health plan you are not eligible for the Integrated HRA.**

**\*\*\*You must provide proof of dependent eligibility i.e. marriage certificate, birth certificate, etc.\*\*\***

**DEPENDENT INFORMATION: (Attach a separate sheet if additional space is needed for additional dependents)**

|                     |                |   |
|---------------------|----------------|---|
| Name:               | Date of Birth: | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Social Security No: |                |   |
| Name:               | Date of Birth: | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Social Security No: |                |   |
| Name:               | Date of Birth: | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Social Security No: |                |   |

**PARTICIPANT AUTHORIZATION**

I hereby authorize the City of Cincinnati to enroll me into the employer sponsored Integrated HRA. I agree to comply with the terms and conditions of the plan. I understand that if the health premium contributions are deducted on an After-Tax Basis, this will result in all premium reimbursements being income tax free. However, if the contributions are on a Pre-Tax Basis, the premium reimbursements will be fully taxable. In either case, the deductible, co-pay and co-insurance reimbursements will remain tax free. I further understand that if any current contributions are made to an HDHP/HSA, I am not eligible to participate in the Integrated HRA offered through the City of Cincinnati.

**Employee Signature:**

**Date:**

**ATTESTATION OF ENROLLMENT – CITY OF CINCINNATI EMPLOYEES  
IN A NON-CITY OF CINCINNATI EMPLOYER GROUP HEALTH PLAN**

**Return form to: Risk Management, 805 Central Avenue, Suite 100**

Employee Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

City Employee ID: \_\_\_\_\_ Email: \_\_\_\_\_

**This form applies to individuals who participate in the Integrated HRA and hereby waive enrollment in the City of Cincinnati Anthem 80/20 medical plan.**

To participate in this program, employees, spouses/equal partners, and dependents must provide proof of enrollment in a non-City of Cincinnati employer group health plan. By signing below, I, a City Employee, certify that:

- The City of Cincinnati has offered me a group health plan (the Anthem 80/20 plan) that provides “minimum value” within the meaning of section 36B(c)(2)(C)(ii) of the Internal Revenue Code (basically a plan rated “bronze” or better under the Patient Protection and Affordable Care Act of 2010).
- I am enrolled in a group health plan of another employer (such as my spouse/equal partner’s employer) that provides “minimum value” within the meaning of section 36B(c)(2)(C)(ii) of the Internal Revenue Code (basically, “bronze” or higher) and that does not consist solely of a health reimbursement arrangement (HRA) under the Internal Revenue Code (that is, a plan that reimburses health care expenses only up to a dollar limit).
- I understand that by enrolling in this HRA, I am waiving participation in the City of Cincinnati Anthem 80/20 Plan.

For confirmation that the other plan meets the IRS's definition of minimum value and does not consist solely of an HRA, please contact the benefits coordinator at the other employer

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse’s Signature

\_\_\_\_\_  
Date

**HRA information contact:  
J & K CONSULTANTS, INC.  
2605 Nicholson Rd., Suite 1140  
Sewickley, PA 15143  
Toll Free Phone: 877-872-4232  
[CinciHRA@JandKcons.com](mailto:CinciHRA@JandKcons.com)  
Toll Free Fax: 877-599-3724  
[Coc.JandKcons.com](http://Coc.JandKcons.com)**



### Integrated HRA Claim Form – City of Cincinnati Employees

**EMPLOYER INFORMATION**

Employer Name: **City of Cincinnati**

**SEND THIS FORM, COPIES OF RECEIPTS, EXPLANATION OF BENEFITS & ANY OTHER CLAIM DOCUMENTATION TO:**

J&K Consultants, Inc.  
2605 Nicholson Road, Suite 1140  
Sewickley, PA 15143

Email: CinciHRA@JandKcons.com  
(Phone): 877-872-4232  
(Fax): 877-599-3724

**PARTICIPANT INFORMATION**

Employee Name:

Employee ID #:

Date of Birth:

**PRESCRIPTION REIMBURSEMENT INFORMATION:**

|       |               |                |
|-------|---------------|----------------|
| Date: | Name of Drug: | Co-Pay Amount: |
| Date: | Name of Drug: | Co-Pay Amount: |
| Date: | Name of Drug: | Co-Pay Amount: |
| Date: | Name of Drug: | Co-Pay Amount: |
| Date: | Name of Drug: | Co-Pay Amount: |
| Date: | Name of Drug: | Co-Pay Amount: |
| Date: | Name of Drug: | Co-Pay Amount: |
| Date: | Name of Drug: | Co-Pay Amount: |
| Date: | Name of Drug: | Co-Pay Amount: |

**PHYSICIAN OFFICE VISITS:**

|                |                |
|----------------|----------------|
| Date of Visit: | Co-Pay Amount: |

**EXPLANATION OF BENEFITS: EOBs**

|                  |              |
|------------------|--------------|
| Date of Service: | Amount Owed: |

**Please Note:** All medical claims must be submitted first through your Non-City sponsored group health plan. An explanation of benefits (EOB) will be provided to you. Only medical expenses approved by that plan will be reimbursed. Therefore, a drug or medical expense that is not covered by your Non-City sponsored group health plan will not be reimbursed. Cancelled checks and/or credit card statements are NOT sufficient proof of your claim. Failure to provide all information will cause a delay in reimbursement.

**EMPLOYEE STATEMENT:**

I hereby certify that the information contained on this Reimbursement Claim Form is to the best of my knowledge and belief true and correct and each item is eligible for reimbursement. I understand that any expenses reimbursed are NOT tax deductible on my individual or joint federal tax return.

***I certify that the amounts above have not been reimbursed under any other health care plan or program, federal, state, or government program, worker's compensation, or any other policy of health insurance, and that I will not seek reimbursement under any of the aforementioned plans, including another HRA or FSA account.***

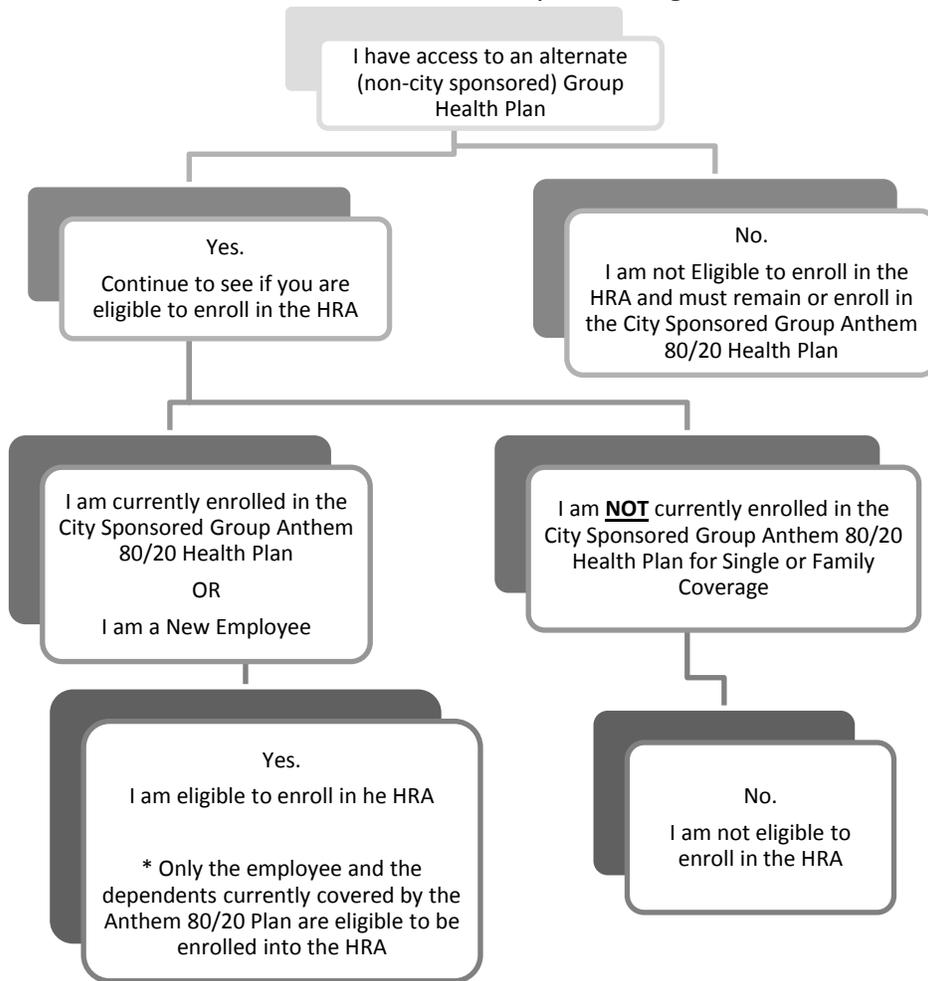
Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**All claims incurred in 2017 must be received no later than March 31, 2018.**

# 2017 City of Cincinnati Employee HRA Benefit



Review this Flow Chart to determine if you are eligible to enroll in the HRA



**Note: If at any point an employee loses access to their alternate group health plan - a Qualifying Event - they will be able to enroll in the City Anthem 80/20 Health Plan**

This plan is administered by J&K Consultants, 2605 Nicholson Rd., Suite 1140, Sewickley, PA 15143  
877-872-4232 (Toll Free Office) • 877-599-3724 (Toll Free Fax) • [CinciHRA@JandKcons.com](mailto:CinciHRA@JandKcons.com)

## Helpful Definitions

**HRA:** Health Reimbursement Arrangement. Reimburses employees and dependents for eligible health care expenses and premium expenses incurred under **non** City sponsored group health coverage.

**Alternate Group Health Plan:** Means any group health coverage, (other than a medical plan sponsored by the City of Cincinnati) available to an Employee, such as through the Employee's spouse/equal partner, another employer of the Employee, or group coverage available to the Employee from any other source including but not limited to eligible retiree benefit programs, other than Medicare, Tricare or the City Retirement System.

**Health Care Expenses:** Deductibles, Co-Pays and Co-Insurance for eligible expenses incurred under the alternate group plan.

**Premiums:** Amount deducted from your spouse/equal partner's pay for the alternative group plan that is reimbursable in an amount that exceeds the cost of the premium that you would pay on the City's plan. If the cost of your alternate coverage increases due to dependent additions, you will receive a reimbursement. If there is no premium increase, you will **not** receive a reimbursement.

**Calendar Year Maximum:** The maximum amount that will be reimbursed for health care expenses and premiums are:

\$5,000/Single  
\$10,000 /Family

## How Does the HRA Work?

**Enroll**

- Enroll in the alternate Group Health Plan.
- Complete the City's HRA Enrollment Form.
- Complete the City's Attestation Form.
- Provide proof of your alternate plan in order to receive premium reimbursements.
- Use HRA ID Card to pay out of pocket expenses at the point of service.

**Incur**

- Doctor's visits
- Prescriptions
- Preventive Screenings
- Urgent care
- Treatments
- Procedures
- Surgeries
- ETC.

**File**

- Present your alternate health plan Health Insurance ID Card.
- Next, present your HRA ID Card for Co-pays, Deductibles and Out of Pockets.
- Your Provider will first file claims with your alternate Health Plan.
- After your provider has received payment for the claim filed, any eligible expense will then be filed by your provider and paid by the HRA Plan.

**Get Reimbursed**

Most claims will be paid directly to the provider through use of the ID card. If **YOU** pay an out of pocket eligible expense, you can always submit a paper claim for reimbursement. (Some pharmacies such as Walgreens, CVS and Mail Order Facilities will not accept the HRA ID Card and will require you to file a paper claim.) You will get a check mailed to your home.

Premium reimbursements will be issued to you through your City paycheck. If your premium contributions are after tax, you will get a check mailed to your home.



HEALTH  
INSURANCE  
FORM

|                     |                   |            |                   |   |                              |
|---------------------|-------------------|------------|-------------------|---|------------------------------|
| Social Security No. | Last Name         | First Name | Initial           | Sex<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female | Date of Birth<br>Mo. Day Yr. |
| Home Address        | Number Street     |            | Date Employed     |   |                              |
|                     | City State        |            | Zip Code          |   | Promotion Date               |
|                     | Home Phone Number |            | Work Phone Number |   | Cell Phone Number            |

|                     |                    |
|---------------------|--------------------|
| Department/Division | CHRIS Employee No. |
|---------------------|--------------------|

|   |   |  |  |                 |
|---|---|--|--|-----------------|
| <input type="checkbox"/> Single<br><input type="checkbox"/> Married | <input type="checkbox"/> Widowed<br><input type="checkbox"/> Divorced | <input type="checkbox"/> Equal Partnership | If adding spouse, marriage date: Mo. Day Yr. | Salary Division |
|---|---|--|--|-----------------|

|  |  |   |                                |
|--|--|---|--------------------------------|
| I ask to:<br><input type="checkbox"/> Become enrolled<br><input type="checkbox"/> Transfer to this group<br><input type="checkbox"/> Add spouse<br><input type="checkbox"/> Drop spouse<br><input type="checkbox"/> Add equal partner<br><input type="checkbox"/> Drop equal partner<br><input type="checkbox"/> Add dependent(s)<br><input type="checkbox"/> Drop dependent(s)<br><input type="checkbox"/> Change name<br><input type="checkbox"/> Change address<br><input type="checkbox"/> Change other ins. info. | <input type="checkbox"/> New enrollment<br><input type="checkbox"/> Open enrollment<br><input type="checkbox"/> Salary Div. change | Is your spouse/equal partner employed?<br><input type="checkbox"/> YES<br><input type="checkbox"/> NO   | Spouse/Equal Partner Employer: |
|  | Date to change name or address<br>Mo. Day Yr.  | <b>PLEASE SELECT:</b><br>Cincinnati 80/20 <input type="checkbox"/> Single <input type="checkbox"/> Family<br>Dental (Fire, Management, Building Trades only) <input type="checkbox"/> Single <input type="checkbox"/> Family<br>Vision (Fire, Management, Building Trades only) <input type="checkbox"/> Single <input type="checkbox"/> Family |                                |
|  | Date to add or drop dependent  | <b>*FOP &amp; AFSCME union employees need to contact their unions for information regarding dental and vision benefits.</b>   |                                |

In order for the City to coordinate benefits (i.e., Healthy Lifestyles Program, etc.), please indicate if spouse/equal partner is another City employee or in the City Retirement system.  City Employee  City Retiree

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

**In the space below, list only the PERSONS you are enrolling, adding or dropping. If the person has other insurance, please indicate and provide details. Attach copies of other insurance cards. See reverse side for instructions regarding eligibility and required supporting documentation.**

| Name - First M Initial Last (if different from Employee) | Street Address City State Zip | Date of Birth Mo. Day Yr. | Relationship | Sex (M or F) | Dependents' Social Security No. | Name of other Health Ins., if applicable (specify) | Other Ins. | Medicare |
|--|-------------------------------|---------------------------|--------------|--------------|---------------------------------|--|------------|----------|
| 1.   |                               |                           |              |              |                                 |  | Y / N      | Y / N    |
| Address  |                               |                           |              |              |                                 | Policy No.   |            |          |
| 2.   |                               |                           |              |              |                                 |  | Y / N      | Y / N    |
| Address  |                               |                           |              |              |                                 | Policy No.   |            |          |
| 3.   |                               |                           |              |              |                                 |  | Y / N      | Y / N    |
| Address  |                               |                           |              |              |                                 | Policy No.   |            |          |
| 4.   |                               |                           |              |              |                                 |  | Y / N      | Y / N    |
| Address  |                               |                           |              |              |                                 | Policy No.   |            |          |
| 5.   |                               |                           |              |              |                                 |  | Y / N      | Y / N    |
| Address  |                               |                           |              |              |                                 | Policy No.   |            |          |

I certify all information is true and correct to the best of my knowledge. I understand that by applying for the type of coverage checked, I authorize my employer to deduct from my wages, if necessary, the required premiums for the coverage hereon applied for. I further authorize any provider of medical, dental, or vision services, insurance company or any other organization to release to the City's health insurance company information regarding my coverage.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

RISK MANAGEMENT USE ONLY: Effective Date: \_\_\_\_\_

# INSTRUCTIONS TO COMPLETE THIS APPLICATION

## ELIGIBILITY & SUPPORTING DOCUMENTATION

- If you are a new employee, you must complete this form and return with all supporting documentation within 31 days of the benefit eligibility date. Otherwise, you must wait until Open Enrollment to enroll in benefits.
- If you are a current employee making changes due to a qualifying life event (change in dependent disability, change in other coverage, birth, death, marriage, divorce, custody, change in equal partner status, etc.) you must complete this form and return with all supporting documentation within 31 days of the qualifying life event. If you are a current employee adding a newborn, you have up to 90 days to provide a copy of the birth certificate only. You are still required to complete this application within 31 days of the birth. Otherwise, you must wait until Open Enrollment to enroll in benefits.
- If you are a current employee who has transferred between salary divisions, this application must be completed and returned to Risk Management within 31 days.
- To be eligible for coverage as a dependent, the dependent must be listed on this health insurance application and be the employee's: legal spouse or equal partner; child (natural child, adopted child, and/or child who the group has determined is covered under a "Qualified Medical Child Support Order"); step-child or child for whom the employee or the employee's spouse/equal partner is a legal guardian.
- To add a spouse, a copy of a state issued marriage certificate and a copy of the front page of the most recent tax return (the dollar amounts should be marked out) are required. You do not need to provide a tax return if you have been married less than twelve months. To remove a spouse outside of open enrollment, a copy of the divorce decree, dissolution, or legal separation is required.
- To add an equal partner, the [Affidavit of Declaration of Financial Interdependence Equal Partner Eligibility Status](#) must be completed, notarized, and submitted with copies of supporting documentation. To remove an equal partner, the [Affidavit of Termination of Declaration of Financial Interdependence](#) must be completed and notarized. Contact Risk Management for the affidavits.
- To add a child, their social security number and copy of their birth certificate is required. If an employee has adopted a child or has legal guardianship, copies of court papers are required.
- All supporting documentation must be returned with this completed application.

## STATE OF OHIO EXTENSION OF DEPENDENT COVERAGE

- Dependent children under the age of 26 are eligible for Cincinnati's 80/20 plan for medical and Rx coverage under the family rate, regardless of school status, marital status or place of residence. Dependent children age 26 to 28, who are unmarried, residents of the state of Ohio or full time students, and have no other available insurance, are eligible for coverage for an additional cost. To apply for the extension of coverage, the [State of Ohio Extension of Dependent Coverage Form](#) must be completed. Contact Risk Management for pricing and the form.

RETURN TO: PHYLISS WARD  
RISK MANAGEMENT  
TWO CENTENNIAL PLAZA  
805 CENTRAL AVE SUITE 100  
CINCINNATI, OH 45202  
P 513 352 2566  
F 513 352 3761

The City of Cincinnati reserves the right to request additional information if needed.



**Important Notice:** You should seek legal advice before signing this affidavit to ensure that you understand the possible legal effects of this acknowledgment of an Equal Partner relationship.

**Affidavit of Declaration of Financial Interdependence  
Equal Partner Eligibility Status**

This affidavit must be completed by both the employee and the declared Equal Partner. The affidavit must be notarized before submitting it to your employer.

**Section 1. Domestic Partnership Requirements**

Employee Name (please print): \_\_\_\_\_  
 Name of Equal Partner (please print): \_\_\_\_\_  
 Address of Employee and Equal Partner: \_\_\_\_\_  
 Equal Partner's Social Security Number: \_\_\_\_\_

In accordance with City Council Motion (item #201200655) adopted May, 2, 2012, an Equal Partner (and children) is eligible for insurance coverage under the City of Cincinnati health plan.

We certify that:

1. neither of us are currently married to or legally separated from another person under statutory or common law; and
2. we share responsibility for each others' common welfare; and
3. we are not related by blood in a manner that would bar our marriage in the State of Ohio; and
4. we are both at least eighteen (18) years of age and mentally competent to consent to contract; and
5. we share the same residence; and
6. we have been in an exclusive relationship with each other for at least 6 months with the intention of remaining in the relationship indefinitely; and
7. we are financially interdependent to each other as demonstrated by a signed declaration of financial interdependence and have provided the City proof of at least four (4) of the following:
  - Joint ownership of real estate property or joint tenancy on a residential lease; or
  - Joint ownership of an automobile; or
  - Joint bank or credit account; or
  - Joint liabilities (e.g., credit cards or loans); or
  - A will designating the eligible Equal Partner as primary beneficiary; or
  - A retirement plan or life insurance policy beneficiary designation form designating the eligible Equal Partner as primary beneficiary; or
  - A durable power of attorney signed to the effect that the employee and eligible Equal Partner have granted powers to one another.

**Section 2. Declaration of Equal Partner**

I declare that the statements in Section 1 are true and correct. I have read and understand the terms and conditions contained in this affidavit. I understand that any misrepresentation of fact in this affidavit may result in any or all of the following actions by the City of Cincinnati: 1) loss of coverage; 2) disciplinary action, up to and including removal; 3) collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible Equal Partners; and/or 4) civil and/or criminal prosecution. Coverage ends when the equal partnership ends. You must report the termination of the partnership. If you do not do so, and obtain insurance benefit payments thereafter, you will be required to repay such benefits in full.

(1) Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

Sworn to and subscribed in my presence this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
SIGNATURE AND SEAL OF NOTARY PUBLIC

I declare that the statements in Section 1 are true and correct. I have read and understand the terms and conditions contained in the affidavit. I understand that any misrepresentation of fact in this affidavit can result in loss of coverage and responsibility to repay in full any insurance benefit payments made in reliance on such misrepresentation or fact. Coverage ends when the domestic partnership ends. You must report the termination of the partnership. If you do not do so, and obtain insurance benefit payments thereafter, you will be required to repay such benefits in full.

(2) Domestic Partner Signature: \_\_\_\_\_ Date \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

Sworn to and subscribed in my presence this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
SIGNATURE AND SEAL OF NOTARY PUBLIC

(3) Additional Information (if necessary)

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# State of Ohio Extension of Dependent Coverage Form

For Ages 26-28



Employee \_\_\_\_\_  
Employee ID# \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Department/Division work location \_\_\_\_\_  
Work phone # \_\_\_\_\_ Home phone # \_\_\_\_\_  
Cell phone # \_\_\_\_\_ Email address \_\_\_\_\_

## Eligible Dependent

Name of Dependent \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship \_\_\_\_\_ Social Security number \_\_\_\_\_  
Dependent's Address \_\_\_\_\_  
Has other insurance Yes \_\_\_ No \_\_\_ Insured 's Name \_\_\_\_\_  
Name of insurance carrier \_\_\_\_\_  
Policy # \_\_\_\_\_ ID # \_\_\_\_\_

Supporting documentation includes: birth certificate; adoption papers; driver's license; and school schedule.

To receive benefits up to the age of 28, the dependent child must be: the natural child, step-child, or adopted child of the employee (dependents covered under guardianship or custody papers are NOT eligible for this extended coverage); a resident of the State of Ohio or a full time student at an institution of higher learning; unmarried; not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and is not eligible for coverage under Medicaid or Medicare.

I certify all information is true and correct to the best of my knowledge. I understand that by applying for this coverage, I authorize the City of Cincinnati to deduct from my wages, the required premiums for the coverage hereon applied for. I further authorize any provider of medical, dental, or vision services, insurance company or any other organization to release to Anthem Blue Cross & Blue Shield any information regarding my coverage.

Employee signature \_\_\_\_\_ Date \_\_\_\_\_

|                                   |
|-----------------------------------|
| Risk Management Use<br>Only       |
| Coverage effective date:<br>_____ |

# Medicare Secondary Payer – Employee Status Form



Please complete this form to indicate compliance with Medicare Secondary Payer regulations of the Centers for Medicare and Medicaid Services (CMS). You may want to check with your legal counsel to confirm the Medicare Secondary Payer requirements. A copy of your Medicare card must accompany this form.

|   |   |
|---|---|
| Name of employee  | Telephone   |
| Identification number (from Anthem ID card)   | Name of Medicare beneficiary  |
| Social Security number of beneficiary   | Medicare (Health Insurance Claim) number  |
| Reason for Medicare eligibility/entitlement<br><input type="checkbox"/> Age<br><input type="checkbox"/> End-Stage Renal Disease (ESRD)<br><input type="checkbox"/> Disability<br><input type="checkbox"/> Disability and current ESRD | Effective date of eligibility/entitlement<br><input type="checkbox"/> Part A _____<br><input type="checkbox"/> Part B _____<br><input type="checkbox"/> Part A&B _____<br><input type="checkbox"/> Part D _____ |

For the Medicare beneficiary named above, please check the appropriate box:

- If Age is the basis of Medicare entitlement (age 65 and over):
  - The coverage under the group health plan is based on current employment status\* of the Medicare beneficiary or spouse.
  - The coverage under the group health plan is not based on current employment status\* of the Medicare beneficiary or spouse.
- If Disability is or was the basis of Medicare entitlement (under age 65):
  - The coverage under the group health plan is based on current employment status\* of the Medicare beneficiary or a member of his/her family.
  - The coverage under the group health plan is not based on current employment status\* of the Medicare beneficiary or a member of his/her family.
  - The employee or dependent is no longer eligible for Medicare.
- If End Stage Renal Disease is the basis of Medicare entitlement (any age):
  - The Medicare beneficiary became entitled to Medicare due to ESRD on \_\_\_\_\_ (date).
- If Disability and End Stage Renal Disease is the basis of Medicare entitlement:
  - The Medicare beneficiary became entitled to Medicare due to disability on \_\_\_\_\_ (date) and due to ESRD on \_\_\_\_\_ (date).

\* "Current employment status" means the individual:

- Is actively working as an employee, is the employer or is associated with the employer in a business relationship; or
- Is not actively working and –
  - Is receiving disability benefits from an employer for up to 6 months; or
  - Retains employment rights in the industry and other specific requirements are met.

You will need to complete this form and return to your Group Administrator.

|                                |      |
|--------------------------------|------|
| Medicare Beneficiary Signature | Date |
|--------------------------------|------|

Group will notify Anthem Blue Cross and Blue Shield as soon as the statements above are no longer true.

|  |              |      |
|--|--------------|------|
| Group administrator's signature (required) | Printed Name | Date |
|--|--------------|------|

Life and Disability products are underwritten by Anthem Life Insurance Company. In Indiana, Anthem Blue Cross and Blue Shield is a trade name of Anthem Insurance Companies, Inc. In Kentucky, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc. In most of Missouri, Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT). Healthy Alliance® Life Insurance Company (HALIC) and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio, Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. In Wisconsin, Blue Cross Blue Shield of Wisconsin ("BCBSWI") underwrites or administers the PPO and Indemnity policies; CompCare Health Services Insurance Corporation ("CompCare") underwrites or administers the HMO policies; and CompCare and BCBSWI collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. © Anthem is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.anthem.com](http://www.anthem.com) or by calling 1-800-887-6055.

| Important Questions  | Answers   | Why this Matters:  |
|--|---|--|
| <p>What is the overall <b>deductible</b>?</p>                    | <p>*Police (Pre 9/15/16), *Fire (Pre 4/27/16), *Building Trades: Network \$300 single/\$600 family; non-network \$600 single/\$1,200 family; Non-Rep, CODE, AFSCME, Police (Post 9/15/16), Fire (Post 4/27/16): Network \$500 single/\$1000 family; non-network \$1000 single/\$2000 family</p>         | <p>You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1<sup>st</sup>). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b>.</p>   |
| <p>Are there other <b>deductibles</b> for specific services?</p> | <p>No</p>   | <p>You don't have to meet <b>deductibles</b> for specific services, but see the chart on page 2 for other costs for services this plan covers.</p>   |
| <p>Is there an <b>out-of-pocket limit</b> on my expenses?</p>    | <p>Yes. *Police (Pre 9/15/16), *Fire (Pre 4/27/16), *Building Trades: Network \$1500 single/\$3000 family; non-network \$3000 single/\$6000 family; Non-Rep, CODE, AFSCME, Police (Post 9/15/16), Fire (Post 4/27/16): Network \$2000 single/\$4000 family; non-network \$4000 single/\$8000 family</p> | <p>The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>  |
| <p>What is not included in the <b>out-of-pocket limit</b>?</p>   | <p>Premiums, balance-billed charges, health care this plan doesn't cover, and prescription co-pays</p>  | <p>Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b>.</p>   |
| <p>Is there an overall annual limit on what the plan pays?</p>   | <p>No</p>   | <p>The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>  |
| <p>Does this plan use a <b>network of providers</b>?</p>         | <p>Yes. For a list of network providers, visit <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-887-6055</p>  | <p>If you use an in-network doctor or other health care <b>provider</b>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b>, or participating for <b>providers</b> in their <b>network</b>. See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b>.</p> |
| <p>Do I need a referral to see a <b>specialist</b>?</p>          | <p>No, if you see a specialist in the Blue Access network.</p>  | <p>You can see the <b>specialist</b> you choose without permission from this plan.</p>   |
| <p>Are there services this plan doesn't cover?</p>               | <p>Yes</p>  | <p>Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about the excluded services.</p>   |

Questions: Call 1-800-887-6055 or visit us at [www.anthem.com](http://www.anthem.com).

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\*Grandfathered Plan

# City of Cincinnati: Blue Access – 80/20 Plan

Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single/Family | Plan Type: PPO



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.



| Common Medical Event  | Services You May Need                            | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions   |
|---|--|---|---|--|
| If you visit a health care <u>provider's office</u> or clinic | Primary care visit to treat an injury or illness | 20%   | 50%   | None   |
|   | Specialist visit                                 | 20%   | 50%   | None   |
|   | Other practitioner office visit                  | 20%   | 50%   | Chiropractic therapy is limited to 12 visits per calendar year.  |
| If you have a test  | Preventive care/screening/immunization           | No charge                                   | 50%   | Physical exams and immunizations required for travel, enrollment in an insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not covered services. |
|   | Diagnostic test (x-ray, blood work)              | 20%   | 50%   | None   |
| If you need drugs to treat your illness or condition          | Imaging (CT/PET scans, MRIs)                     | 20%   | 50%   | None   |
|   | Generic drugs                                    | \$10/prescription                           | 100%  | None   |
|   | Preferred brand drugs                            | \$20/prescription                           | 100%  | None   |
|   | Non-preferred brand drugs                        | \$30/prescription                           | 100%  | None   |

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# City of Cincinnati: Blue Access – 80/20 Plan

Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single/Family | Plan Type: PPO

| Common Medical Event  | Services You May Need                          | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions        |
|---|--|---|---|---------------------------------|
| More information about <b>prescription drug coverage</b> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> | Specialty drugs                                | \$30/prescription                           | 100%  | None                            |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center) | 20%   | 50%   | None                            |
|   | Physician/surgeon fees                         | 20%   | 50%   | None                            |
| If you need immediate medical attention   | Emergency room services                        | 20%   | 20%   | Co-insurance waived if admitted |
|   | Emergency medical transportation               | 20%   | 20%   | None                            |
|   | Urgent care                                    | 20%   | 20%   | None                            |
| If you have a hospital stay   | Facility fee (e.g., hospital room)             | 20%   | 50%   | None                            |
|   | Physician/surgeon fee                          | 20%   | 50%   | None                            |
| If you have mental health, behavioral health, or substance abuse needs  | Mental/Behavioral health outpatient services   | 20%   | 50%   | None                            |
|   | Mental/Behavioral health inpatient services    | 20%   | 50%   | None                            |
|   | Substance use disorder outpatient services     | 20%   | 50%   | None                            |
|   | Substance use disorder inpatient services      | 20%   | 50%   | None                            |
| If you are pregnant   | Prenatal and postnatal care                    | 20%   | 50%   | None                            |
|   | Delivery and all inpatient services            | 20%   | 50%   | None                            |

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# City of Cincinnati: Blue Access – 80/20 Plan

Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single/Family | Plan Type: PPO

| Common Medical Event   | Services You May Need                  | Your Cost If You Use an In-network Provider | Your Cost if You Use an Out-of-network Provider | Limitations & Exceptions  |
|--|--|---|---|---|
| If you need help recovering or have other special health needs | Home health care                       | 20%   | 50%   | Limited to 30 visits non-network (excludes IV therapy)  |
|  | Rehabilitation services                | 20%   | 50%   | Physical medicine/rehab (network & non-network combined for all limits) limited to 60 days. Physical/occupational therapy limited to 60 combined visits per calendar year. Speech therapy limited to 20 visits per calendar year. |
|  | Habilitation services                  | 20%   | 50%   | All rehabilitation and habilitation visits count toward your rehabilitation visit limit.  |
|  | Skilled nursing care                   | 20%   | 50%   | None  |
|  | Durable medical equipment              | 20%   | 50%   | None  |
|  | Hospice service                        | 20%   | 20%   | None  |
|  | Eye exam                               | No charge                                   | 50%   | Preventive exam   |
|  | Glasses                                | Not covered                                 | Not covered                                     | None  |
|  | Dental check-up                        | Not covered                                 | Not covered                                     | None  |
|  | If your child needs dental or eye care |   |   |   |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult) unless it is related to accidental injury</li> <li>• Hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long term care</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|--|--|

Questions: Call 1-800-887-6055 or visit us at [www.anthem.com](http://www.anthem.com).

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**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Non-emergency care when traveling outside the U.S.

- For coverage provided outside the United States, call 1-800-810-2583
- Gender reassignment surgery

### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-887-6055. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Anthem Grievance and Appeals, PO Box 105568, Atlanta, Georgia 30348 and/or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

### Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [1-800-887-6055].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-800-887-6055].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [1-800-887-6055].]

[Navajo (Dine): Dinek'ehgo shika at'ohvol niniisingo, kwijigo holne' [1-800-887-6055].]

—To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call 1-800-887-6055 or visit us at [www.anthem.com](http://www.anthem.com).

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,890
- Patient pays \$1,650

#### Sample care costs:

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$300          |
| Copays               | \$0            |
| Coinsurance          | \$1,200        |
| Limits or exclusions | \$150          |
| <b>Total</b>         | <b>\$1,650</b> |

### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,180
- Patient pays \$1,220

#### Sample care costs:

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$2,900        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$700          |
| Education                      | \$300          |
| Laboratory tests               | \$100          |
| Vaccines, other preventive     | \$100          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$300          |
| Copays               | \$400          |
| Coinsurance          | \$440          |
| Limits or exclusions | \$80           |
| <b>Total</b>         | <b>\$1,220</b> |

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-887-6055 or visit us at [www.andhem.com](http://www.andhem.com).

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# City of Cincinnati Employees

Coverage Period: (1/1/17 to 12/31/17)

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Integrated HRA **Plan Type:** Integrated HRA

## Questions and answers about the Coverage Examples:

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [coc.jandkcons.com](http://coc.jandkcons.com) or by calling J & K at 888-872-4232.

| Important questions  | Answers   | Why this Matters:   |
|--|---|---|
| <b>What is the overall Deductible?</b>                         | None  | This plan reimburses any deductible incurred by plan participants on alternate coverage.  |
| <b>Are there other Deductibles for specific services?</b>      | No  | This plan reimburses any deductible incurred by plan participants on alternate coverage.  |
| <b>Is there an out-of-pocket limit on my expenses?</b>         | No  | This plan reimburses any "Max out of pocket" expenses incurred by plan participants on alternate coverage.  |
| <b>What is not included in the out-of-pocket limit?</b>        | N/A   |   |
| <b>Is there an overall annual limit on what the plan pays?</b> | Single - \$5,000 per year<br>Family - \$10,000 per year | This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the maximums allowed.  |
| <b>Does this plan use a network of providers?</b>              | Indirectly only   | This plan reimburses for certain expenses not paid by the alternate coverage, and the alternate coverage may use a network of providers.  |
| <b>Do I need a referral to see a specialist?</b>               | Indirectly only   | This plan reimburses for certain expenses not paid by the alternate coverage, And the alternate coverage may require a referral to see the specialist.  |
| <b>Are there services this plan doesn't cover?</b>             | Yes   | You may have a cost under the alternate coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage. Any procedure not covered by the alternate coverage will not be covered under this plan. |

**Questions:** Call J & K Consultants, Inc. at 877-872-4232 or visit us at [coc.jandkcons.com](http://coc.jandkcons.com).

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Questions and answers about the Coverage Examples:

- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$ 1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.



| Common Medical Event  | Services You May Need   | Your cost if you use an |                         | Limitations & Exceptions  |
|---|---|-------------------------|-------------------------|---|
|   |   | In-network Provider     | Out-of-network provider |   |
| <b>If you visit a health care provider's office or clinic</b> | Primary care visit to treat an injury or illness                    |                         |                         | You may have a cost under the alternate coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage. Any procedure not covered by the alternate coverage will not be covered under this plan. |
|   | Specialist visit  |                         |                         |   |
|   | Other practitioner office visit                                     | 0                       | 0                       |   |
| <b>If you have a test</b>                                     | Preventive care/screening/immunization                              | 0                       | 0                       | You may have a cost under the alternate coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage. Any procedure not covered by the alternate coverage will not be covered under this plan. |
|   | Diagnostic test (x-ray, blood work)<br>Imaging (CT/PET scans, MRIs) | 0                       | 0                       |   |

**Questions:** Call J & K Consultants, Inc. at 877-872-4232 or visit us at [coc.jandkcons.com](http://coc.jandkcons.com).

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# City of Cincinnati Employees

Coverage Period: (1/1/17 to 12/31/17)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Integrated HRA Plan Type: Integrated HRA

## Questions and answers about the Coverage Examples:

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.</a> | Generic drugs                                  |   |   |   | Any drug not covered by the participants' alternate coverage will not be covered under this plan.   |
|   | Preferred brand drugs                          |   |   |   |   |
|   | Non-preferred brand drugs                      |   |   |   |   |
|   | Specialty drugs                                | 0 | 0 | 0 |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center) |   |   |   | You may have a cost under the alternate coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage. Any procedure not covered by the alternate coverage will not be covered under this plan. |
|   | Physician / surgeon fees                       | 0 | 0 | 0 |   |
| <b>If you need</b>  | Emergency room services                        |   |   |   | You may have a cost under the alternate coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage. Any procedure not covered by the alternate coverage will not be covered under this plan. |
|   |  | 0 | 0 | 0 |   |
| <b>Immediate medical attention</b>  | Emergency medical transportation               |   |   |   | You may have a cost under the alternate coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage. Any procedure not covered by the alternate coverage will not be covered under this plan. |
|   | Urgent care                                    | 0 | 0 | 0 |   |

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# City of Cincinnati Employees

Coverage Period: (1/1/17 to 12/31/17)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Integrated HRA Plan Type: Integrated HRA

## Questions and answers about the Coverage Examples:

|  |  |          |          |  |
|--|--|----------|----------|--|
| <p><b>If you have a hospital stay</b></p>  | <p>Facility fee (e.g., hospital room)<br/>Physician / surgeon fee</p>  | <p>0</p> | <p>0</p> | <p>plan.<br/>You may have a cost under the alternate coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage. Any procedure not covered by the alternate coverage will not be covered under this plan.</p> |
| <p><b>If you have mental health, behavioral health, or substance abuse needs</b></p> | <p>Mental/Behavioral health outpatient services<br/>Mental/Behavioral health inpatient services<br/>Substance use disorder outpatient services<br/>Substance use disorder inpatient services</p> | <p>0</p> | <p>0</p> | <p>You may have a cost under the alternate coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage. Any procedure not covered by the alternate coverage will not be covered under this plan.</p>           |
| <p><b>If you are pregnant</b></p>  | <p>Prenatal and postnatal care<br/>Delivery and all inpatient services</p>   | <p>0</p> | <p>0</p> | <p>You may have a cost under the alternate coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage. Any procedure not covered by the alternate coverage will not be covered under this plan.</p>           |
| <p><b>If you need help recovering or have other special health needs</b></p>         | <p>Home health care<br/>Rehabilitation services<br/>Habilitation services<br/>Skilled nursing care<br/>Durable medical equipment</p>   | <p>0</p> | <p>0</p> | <p>You may have a cost under the alternate coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage. Any procedure not covered by the alternate coverage will not be covered under this plan.</p>           |

Questions: Call J & K Consultants, Inc. at 877-872-4232 or visit us at [coc.jandkcons.com](http://coc.jandkcons.com).

If you aren't clear about any of the terms used in this form, see the Glossary. You can View the Glossary at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-470-2963 to request a copy.

# City of Cincinnati Employees

Coverage Period: (1/1/17 to 12/31/17)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Integrated HRA Plan Type: Integrated HRA

Questions and answers about the Coverage Examples:

|   | Hospice service | 0   | 0   | alternate coverage will not be covered under this plan. |
|---|-----------------|-----|-----|---|
| <b>If your child needs dental or eye care</b> | Eye exam        | N/A | N/A | None  |
|   | Glasses         | N/A | N/A | None  |
|   | Dental check-up | N/A | N/A | None  |

## EXCLUDED SERVICES & OTHER COVERED SERVICES:



**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other [excluded services](#).)

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 513-352-256. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 X61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

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## City of Cincinnati Employees

Coverage Period: (1/1/17 to 12/31/17)

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Integrated HRA   **Plan Type:** Integrated HRA

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### Questions and answers about the Coverage Examples:

- Your Claim administrator at 877-872-4232.
- The Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthform](http://www.dol.gov/ebsa/healthform). To see examples of how this plan might cover costs for a sample medical situation, see the next page.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **Yes - (see IRS Notice 2013-54).**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **N/A – integrated with standard plan.**

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Questions and answers about the Coverage Examples:

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: **\$7,540**
- Plan pays \$
- Patient pays \$

**Sample care costs:**

|                            |                |
|----------------------------|----------------|
| Hospital charges (mother)  | \$2,700        |
| Routine obstetric care     | \$2,100        |
| Hospital charges (baby)    | \$900          |
| Anesthesia                 | \$900          |
| Laboratory tests           | \$500          |
| Prescriptions              | \$200          |
| Radiology                  | \$200          |
| Vaccines, other preventive | \$40           |
| <b>Total</b>               | <b>\$7,540</b> |

|                      |             |
|----------------------|-------------|
| Patient pays:        |             |
| Deductibles          | \$ 0        |
| Co-pays              | \$ 0        |
| Co-insurance         | \$ 0        |
| Limits or exclusions | \$ 0        |
| <b>Total</b>         | <b>\$ 0</b> |

### Managing type 2 diabetes (routine maintenance of a well-controlled)

- Amount owed to providers: **\$4,100**
- Plan pays \$
- Patient pays \$

**Sample care costs:**

|                                |                |
|--------------------------------|----------------|
| Prescriptions                  | \$1,500        |
| Medical Equipment and Supplies | \$1,300        |
| Office Visits and Procedures   | \$730          |
| Education                      | \$290          |
| Laboratory tests               | \$140          |
| Vaccines, other preventive     | \$140          |
| <b>Total</b>                   | <b>\$4,100</b> |

|                      |             |
|----------------------|-------------|
| Patient pays:        |             |
| Deductibles          | \$ 0        |
| Co-pays              | \$ 0        |
| Co-insurance         | \$ 0        |
| Limits or exclusions | \$ 0        |
| <b>Total</b>         | <b>\$ 0</b> |

**Questions:** Call J & K Consultants, Inc. at 877-872-4232 or visit us at [coc.jandkcons.com](http://coc.jandkcons.com).

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Questions and answers about the Coverage Examples:

**What are some of the assumptions behind the Coverage Examples?**

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

**What does a Coverage Example show?**

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

**Does the Coverage Example predict my own care needs?**

**NO.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

**Does the Coverage Example predict my future expenses?**

**NO.** Coverage Examples are NOT cost estimators. You can't use the examples to estimate costs for an actual condition. They are for your comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

**Can I use Coverage Examples to compare plans?**

**YES.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

**Are there other costs I should consider when comparing plans?**

**YES.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending accounts (FSAs) or Health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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If you aren't clear about any of the terms used in this form, see the Glossary. You can View the Glossary at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-470-2963 to request a copy.

Following are important notices regarding your health benefits. These notices are intended to make you aware of certain rights and obligations under the benefits plan.

### **Women's Health and Cancer Rights Act of 1998 (WHCRA)**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For an individual receiving mastectomy-related benefits, coverage will be provided in a manner determined by consultation with the attending physician and patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema in a manner determined in consultation with the attending physician and the patient

### **Special Enrollment**

If you are declining enrollment for you or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll you or your dependents in the plan, provided that your request enrollment within 30 days after your other coverage ends (COBRA or state continuation coverage ends, divorce, legal separation, death, termination of employment or reduction in hours worked; or because the employer contributions cease).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll you and your dependents, provided you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you decline enrollment for yourself or for your dependents (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

**If you have any questions, please contact Phyliss Ward at 513-352-2566.**

### **Michelle's Law**

Michelle's Law prohibits the termination of health coverage if the child takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must:

- Be medically necessary (and certified by a physician as medically necessary)
- Commence while the child is suffering from a serious illness or injury
- Cause the child to lose student status for the purposes of coverage under the plan (either from an absence from school or reducing his/her course load to part time)

To take advantage of the extension, the child must be enrolled in the group health plan by being a student at a post-secondary educational institution immediately before the first day of the leave. Coverage must extend for one year after the first day of the leave (or, if earlier, the date coverage would otherwise terminate under the plan). The student on leave is entitled to the same benefits as if they had not taken a leave. If coverage changes during the student's leave, then this law applies in the same manner as the prior coverage.

### **Notice of Grandfather Status**

The Anthem 80/20 plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act) for the following employee divisions: Building Trades, Police (hired before 9/8/16), and Fire (hired before 4/27/16). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).

**Premium Assistance Under Medicaid and the  
Children’s Health Insurance Program (CHIP)**

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –**

|  |   |
|--|---|
| <p><b>ALABAMA – Medicaid</b><br/>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a><br/>Phone: 1-855-692-5447</p>  | <p><b>FLORIDA – Medicaid</b><br/>Website: <a href="http://flmedicaidprecovery.com/hipp/">http://flmedicaidprecovery.com/hipp/</a><br/>Phone: 1-877-357-3268</p>   |
| <p><b>ALASKA – Medicaid</b><br/>The AK Health Insurance Premium Payment Program<br/>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a><br/>Phone: 1-866-251-4861<br/>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a><br/>Medicaid Eligibility:<br/><a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></p> | <p><b>GEORGIA – Medicaid</b><br/>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a><br/>- Click on Health Insurance Premium Payment (HIPP)<br/>Phone: 404-656-4507</p>  |
| <p><b>ARKANSAS – Medicaid</b><br/>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a><br/>Phone: 1-855-MyARHIPP (855-692-7447)</p>  | <p><b>INDIANA – Medicaid</b><br/>Healthy Indiana Plan for low-income adults 19-64<br/>Website: <a href="http://www.hip.in.gov">http://www.hip.in.gov</a><br/>Phone: 1-877-438-4479<br/>All other Medicaid<br/>Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a><br/>Phone 1-800-403-0864</p> |
| <p><b>COLORADO – Medicaid</b><br/>Medicaid Website: <a href="http://www.colorado.gov/hcpf">http://www.colorado.gov/hcpf</a><br/>Medicaid Customer Contact Center: 1-800-221-3943</p>   | <p><b>IOWA – Medicaid</b><br/>Website: <a href="http://www.dhs.state.ia.us/hipp/">http://www.dhs.state.ia.us/hipp/</a><br/>Phone: 1-888-346-9562</p>  |

|  |  |
|--|--|
| <b>KANSAS – Medicaid</b>   | <b>NEVADA – Medicaid</b>   |
| Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a><br>Phone: 1-785-296-3512  | Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a><br>Medicaid Phone: 1-800-992-0900  |
| <b>KENTUCKY – Medicaid</b>   | <b>NEW HAMPSHIRE – Medicaid</b>  |
| Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a><br>Phone: 1-800-635-2570  | Website: <a href="http://www.dhhs.nh.gov/oii/documents/hippapp.pdf">http://www.dhhs.nh.gov/oii/documents/hippapp.pdf</a><br>Phone: 603-271-5218  |
| <b>LOUISIANA – Medicaid</b>  | <b>NEW JERSEY – Medicaid and CHIP</b>  |
| Website:<br><a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a><br>Phone: 1-888-695-2447   | Medicaid Website:<br><a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a><br>Medicaid Phone: 609-631-2392<br>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a><br>CHIP Phone: 1-800-701-0710                          |
| <b>MAINE – Medicaid</b>  | <b>NEW YORK – Medicaid</b>   |
| Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a><br>Phone: 1-800-442-6003<br>TTY: Maine relay 711  | Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a><br>Phone: 1-800-541-2831  |
| <b>MASSACHUSETTS – Medicaid and CHIP</b>   | <b>NORTH CAROLINA – Medicaid</b>   |
| Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a><br>Phone: 1-800-462-1120  | Website: <a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a><br>Phone: 919-855-4100  |
| <b>MINNESOTA – Medicaid</b>  | <b>NORTH DAKOTA – Medicaid</b>   |
| Website: <a href="http://mn.gov/dhs/ma/">http://mn.gov/dhs/ma/</a><br>Phone: 1-800-657-3739  | Website:<br><a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a><br>Phone: 1-844-854-4825   |
| <b>MISSOURI – Medicaid</b>   | <b>OKLAHOMA – Medicaid and CHIP</b>  |
| Website:<br><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a><br>Phone: 573-751-2005   | Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a><br>Phone: 1-888-365-3742  |
| <b>MONTANA – Medicaid</b>  | <b>OREGON – Medicaid</b>   |
| Website:<br><a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a><br>Phone: 1-800-694-3084   | Website: <a href="http://www.oregonhealthykids.gov">http://www.oregonhealthykids.gov</a><br><a href="http://www.hijossaludablesoregon.gov">http://www.hijossaludablesoregon.gov</a><br>Phone: 1-800-699-9075   |
| <b>NEBRASKA – Medicaid</b>   | <b>PENNSYLVANIA – Medicaid</b>   |
| Website:<br><a href="http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx</a><br>Phone: 1-855-632-7633 | Website: <a href="http://www.dhs.pa.gov/hipp">http://www.dhs.pa.gov/hipp</a><br>Phone: 1-800-692-7462  |
| <b>RHODE ISLAND – Medicaid</b>   | <b>VIRGINIA – Medicaid and CHIP</b>  |
| Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a><br>Phone: 401-462-5300  | Medicaid Website:<br><a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a><br>Medicaid Phone: 1-800-432-5924<br>CHIP Website:<br><a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a><br>CHIP Phone: 1-855-242-8282 |

|   |  |
|---|--|
| <b>SOUTH CAROLINA – Medicaid</b>  | <b>WASHINGTON – Medicaid</b>   |
| Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a><br>Phone: 1-888-549-0820   | Website: <a href="http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx">http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx</a><br>Phone: 1-800-562-3022 ext. 15473                               |
| <b>SOUTH DAKOTA – Medicaid</b>  | <b>WEST VIRGINIA – Medicaid</b>  |
| Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a><br>Phone: 1-888-828-0059   | Website: <a href="http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx">http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx</a><br>Phone: 1-877-598-5820, HMS Third Party Liability |
| <b>TEXAS – Medicaid</b>   | <b>WISCONSIN – Medicaid and CHIP</b>   |
| Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a><br>Phone: 1-800-440-0493   | Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a><br>Phone: 1-800-362-3002  |
| <b>UTAH – Medicaid and</b>  | <b>WYOMING – Medicaid</b>  |
| Website:<br>Medicaid: <a href="http://health.utah.gov/medicaid">http://health.utah.gov/medicaid</a><br>CHIP: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a><br>Phone: 1-877-543-7669 | Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a><br>Phone: 307-777-7531  |
| <b>VERMONT - Medicaid</b>   |  |
| Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a><br>Phone: 1-800-250-8427   |  |

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

October 3, 2016



**Re: Continuation Coverage Rights Under COBRA**

Dear Employee:

You're getting this notice because you recently gained coverage under the City's group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

**What is COBRA continuation coverage?**

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

**When is COBRA continuation coverage available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), the employee or a family member has a legal obligation to notify the City of Cincinnati or the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Anthem Benefits Administration 1-866-800-2272 or [cobraservices@benefitadminsolutions.com](mailto:cobraservices@benefitadminsolutions.com).**

## **How is COBRA continuation coverage provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

### **Disability extension of 18-month period of COBRA continuation coverage**

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. To benefit from this extension, a qualified beneficiary must notify the Plan Administrator of that determination within 60 days and before the end of the original 18-month period. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

### **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

### **Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

### **If you have questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

### **Keep your Plan informed of address changes**

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

### **Plan contact information**

If you have any questions about COBRA, please contact Phylliss Ward at (513)352-2566. Also, if you have a change in family status (marriage, divorce, birth, death etc.) please complete a Health Insurance Form and forward it to City of Cincinnati Risk Management, 805 Central Avenue, Suite 100, Cincinnati, Ohio 45202 within 31 days of the change.

Very truly yours,

Deborah Allison  
Risk Manager

## NOTICE

### CITY OF CINCINNATI

#### HEALTH PLAN PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

#### USE AND DISCLOSURE OF HEALTH INFORMATION

The Health Plan may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Health Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

**To Make or Obtain Payment.** The Health Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

**To Conduct Health Care Operations.** The Health Plan may use or disclose health information for its own operations to facilitate the administration of the Health Plan and as necessary to provide coverage and services to all of the Health Plan's participants. Health Care Operations include such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Health Plan, including customer service and resolution of complaints.

**For Treatment Alternatives.** The Health Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**For Distribution of Health-Related Benefits and Services.** The Health Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

**For Disclosure to the Plan Sponsor.** The Health Plan may disclose your health information to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of the Health Plan. In addition, the Health Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan. The Health Plan may also disclose to the plan sponsor information on whether you are participating in the health plan.

**When Legally Required.** The Health Plan will disclose your health information when it is required to do so by any federal, state, or local law.

**To Conduct Health Oversight Activities.** The Health Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Health Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

**In Connection With Judicial and Administrative Proceedings.** As permitted or required by state law, the Health Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Health Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

**For Law Enforcement Purpose.** As permitted or required by state law, the Health Plan may disclose your health information to a law enforcement official for certain law enforcement purpose, including, but not limited to, if the Health Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

**In the Event of a Serious Threat to Health or Safety.** The Health Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Health Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

**For Specified Government Functions.** In certain circumstances, federal regulations require the Health Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

**For Workers' Compensation.** The Health Plan may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

## **AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

Other than as stated above, the Health Plan will not disclose your health information other than with your written authorization. If you authorize the health plan to use or disclose your health information, you may revoke that authorization in writing at any time.

## **YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION**

You may have the following rights regarding your health information that the Health Plan maintains:

**Right to Request Restrictions.** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Health Plan's disclosure of your health information to someone involved in the payment of your care. However, the Health Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the Division of Risk Management at (513) 352-2418.

**Right to Receive Confidential Communications.** You have the right to request that the Health Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Health Plan only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to: Division of Risk Management, 805 Central Avenue, Centennial Plaza Two - Suite 100, Cincinnati, OH. 45202 fax (513) 352-3761. The Health Plan will attempt to honor your reasonable requests for confidential communications.

**Right to Inspect and Copy Your Health Information.** You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to: Division of Risk Management, 805 Central Avenue, Centennial Plaza Two – Suite 100, Cincinnati, OH. 45202 fax (513) 352-3761. If you request a copy of your health information, the Health Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

**Right to Amend Your Health Information.** If you believe that your health information records are inaccurate or incomplete, you may request that the Health Plan amend the records. That request may be made as long as the information is maintained by the Health Plan. A request for an amendment of records must be made in writing to: the Division of Risk Management, 805 Central Avenue, Centennial Plaza Two – Suite 100, Cincinnati, OH. 45202 fax (513) 352-3761. The Health Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Health Plan, if the health information you are requesting to amend is not part of the Health Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Health Plan determines the records containing your health information are accurate and complete.

**Right to an Accounting.** You have the right to request a list of certain disclosures of your health information that the Health Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing to the Division of Risk Management, 805 Central Avenue, Centennial Plaza Two – Suite 100, Cincinnati, OH. 45202 fax (513) 352-3761. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Health Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Health Plan will inform you in advance of the fee, if applicable.

**Right to a Paper Copy of this Notice.** You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact Risk Management at (513) 352-2418. You may also obtain a copy of the current version of the Health Plan's Notice at the City's Web site at <http://citymatters.rcc.org/finance/riskmgt/>.

## **DUTIES OF THE HEALTH PLAN**

The Health Plan is required by law to maintain the privacy of your health plan information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Health Plan is required to abide by the terms of this notice, which may be amended from time to time. The Health Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Health Plan changes its policies and procedures, the Health Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Health Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Health Plan should be made in writing to: Ms. Deborah Allison, Privacy Official, Division of Risk Management, 805 Central Avenue, Centennial Plaza Two – Suite 100, Cincinnati, OH. 45202. The Health Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

## **CONTACT PERSON**

The Health Plan has designated the Privacy Official as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at: Ms. Deborah Allison, Privacy Official, Division of Risk Management, 805 Central Avenue, Centennial Plaza Two – Suite 100, Cincinnati, OH. 45202, phone number (513) 352-2418.

## **EFFECTIVE DATE**

This Notice is effective April 14, 2003.

**IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT THE PRIVACY OFFICIAL AT THE DIVISION OF RISK MANAGEMENT, 805 CENTRAL AVENUE, CENTENNIAL PLAZA TWO – SUITE 100, CINCINNATI, OH. 45202, PHONE ( 513) 352-2418.**

## Important Notice from the City of Cincinnati About Your Prescription Drug Coverage and Medicare

The City of Cincinnati is sending you this notice because you have a Medical policy that includes benefits for prescription drugs. Now that Medicare Part D is available, Medicare Eligible individuals have more choices in prescription drug coverage.

Please read this notice carefully and keep it where you can find it. This notice has information about current prescription drug coverage with the City of Cincinnati for people who are Medicare eligible or will become Medicare eligible in 2016. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

**If you are not Medicare eligible, and none of your covered family members are Medicare eligible, no action is required on your part.**

**Medicare Eligible Members:** Read this notice carefully - it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

It has been determined that the prescription drug coverage offered by the City of Cincinnati through OptumRx is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay, and is Creditable Coverage.

**Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.**

### **When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15<sup>th</sup> through December 7<sup>th</sup>. If you drop your City of Cincinnati coverage and you choose to wait to join a Medicare drug plan, you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition, if you lose or decide to leave the City's sponsored coverage; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Stand-alone Medicare prescription drug plan. **If you decide to drop your City of Cincinnati Medical plan with prescription drug coverage, be aware that you may not be able to get this coverage back.**

You should also know that if you drop or lose your coverage with the City of Cincinnati and don't enroll in Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next October to enroll.

**For more information about this notice or your current prescription drug coverage...**

Contact our office for further information – Sheila Laffey (513)352-8230. NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You may also request a copy.

**For more information about your options under Medicare prescription drug coverage...**

More detailed information about Medicare plans that offer prescription drug coverage will be available in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit [www.medicare.gov](http://www.medicare.gov) for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).**

# Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

## Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

## Appeal

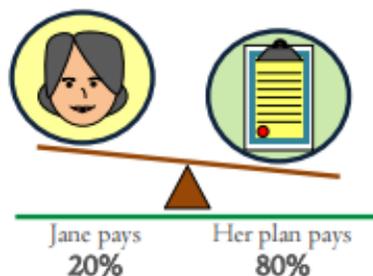
A request for your health insurer or **plan** to review a decision or a **grievance** again.

## Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may **not** balance bill you for covered services.

## Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance **plus** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



## Complications of Pregnancy

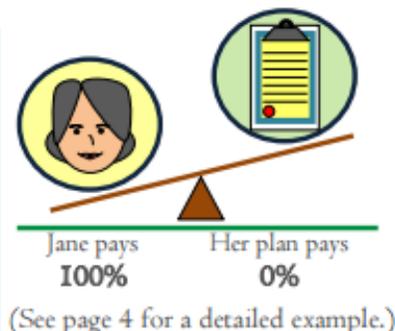
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

## Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

## Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



## Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

## Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

## Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

## Emergency Room Care

**Emergency services** you get in an emergency room.

## Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

## Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

## Grievance

A complaint that you communicate to your health insurer or **plan**.

## Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

## Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

## Home Health Care

Health care services a person receives at home.

## Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

## Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

## Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

## In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

## In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

## Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

## Network

The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

## Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or **plan**, or if your health insurance or **plan** has a "tiered" **network** and you must pay extra to see some providers.

## Out-of-network Co-insurance

The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

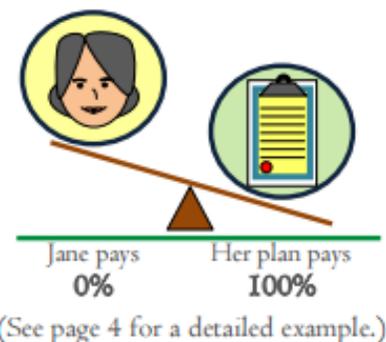
## Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

## Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health

insurance or **plan** doesn't cover. Some health insurance or **plans** don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



## Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

## Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

## Preauthorization

A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

## Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

## Premium

The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

## Prescription Drug Coverage

**Health insurance** or **plan** that helps pay for **prescription drugs** and medications.

## Prescription Drugs

Drugs and medications that by law require a prescription.

## Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

## Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

## Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

## Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

## Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

## Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

## Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

## UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

## Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

# How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500

Co-insurance: 20%

Out-of-Pocket Limit: \$5,000

